Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: RECEPT PHARMACY LP PO BOX 15640 FORT WORTH TX 76119	MFDR Tracking #: M4-05-5003-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: ROYAL INDEMNITY CO Box #: 11	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We have submitted a claim to the Carrier for date of service 05-06-04 for a post op wound care pack." "Total dollar amount in dispute is **$47.86.**" "The disputed issue is that the Carrier has denied the charges as 'G-unbundling.' We resubmitted the claims to the Carrier requesting payment. The Carrier denied the request for payment stating the same." "The expected out come of this issue is that we feel the claim should be paid in full. According to TWCC this payment exception code is used when payment is denied because the charge is included in another billed procedure. These charges are not included in any other billed procedure on the same date. All items billed are individual items needed for the patient's home use for after surgery care. As the billed items are individual separate items not related to any other billed procedure, payment should be rendered."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought $47.86

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a position summary in the response to this request for medical fee dispute resolution.

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
3/22/2004	A6203(X6)	$3.35 X 6 = $20.10. This amount multiplied by 125% = $25.13. This amount minus previously paid of $0.00 = $25.13.	$25.13	$25.13
	A6255 (X6)	$3.03 X 6 = $18.18. This amount multiplied by 125% = $22.73. This amount minus previously paid of $0.00 = $22.73	$22.73	$22.73
			Total Due:	$47.86

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on March 8, 2005. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 16, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
3. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 7/28/2004

   - G-Unbundling

Issues

1. Was the dispute filed in the form and manner prescribed under Division rules at 28 TAC §133.307?
2. Is the respondent's denial supported?
3. What is the applicable rule for reimbursement?
4. Is the requestor entitled to additional reimbursement

Findings

1. Division rule at 28 TAC §133.307(e)(2)(C), requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." The Division notes that the requestor has listed the disputed date of service as 5/6/2004 on the Table of Disputed Services; however, the medical bill and EOBs are for date of service 3/22/2004. The Division determined that a typographical error was made on the Table of Disputed Services and that the disputed date is 3/22/2004. The Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(1)(C).
2. On the disputed date of service the requestor billed HCPCS code A6255, A6203 and E1399. The respondent paid for HCPCS code E1399-Post op dispensing bag at $10.00. The Division finds that the disputed services are not global to the post-op dispensing bag; therefore, the respondent's denial is not supported in accordance with Division rule at 28 TAC §134.202.
3. Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."
   - HCPCS code A6203 is described as "Composite dressing, sterile, pad size 16 sq in or less, with any size adhesive border, each dressing." Per DMEPOS, HCPCS code A6255 has a fee of $3.35.
   - HCPCS code A6255 is described as "Specialty absorptive dressing, wound cover, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any adhesive border, each dressing." Per DMEPOS, HCPCS code A6255 has a fee of $3.03.
4. Reimbursement will therefore be calculated according to Division rule at 28 TAC §134.202(c)(2), for HCPCS codes A6255 and A6402.
   - Per DMEPOS, HCPCS code A6203 has a MAR of $3.35. On the disputed date of service the requestor billed for 6 units. $3.35 X 6 = $20.10. This amount multiplied by 125% = $25.13. This amount minus previously paid of $0.00 = $25.13. This amount is recommended for reimbursement.
   - Per DMEPOS, HCPCS code A6255 has a MAR of $3.03. On the disputed date of service the requestor billed for 6 units. $3.03 X 6 = $18.18. This amount multiplied by 125% = $22.73. This amount minus previously paid of $0.00 = $22.73. This amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor for HCPCS codes A6203 and A6255. For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $47.86.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $47.86 additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $47.86 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**June 25, 2010**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.